

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-017606

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

STATE FILE NUMBER

318
FILED MAY 9 1963

1003

4764

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)

Length of stay in 1b

OR TOWN

c. FULL NAME OF (If NOT in hospital, give location)

HOSPITAL OR INSTITUTION

Inside Limits

Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived; if institution: Residence before admission)

a. STATE

b. COUNTY

admission)

c. CITY OR TOWN

Inside Limits

Yes ☐ No ☒

d. STREET ADDRESS

(If outside, give location)

Reside on Farm

Yes ☐ No ☒

3. NAME OF DECEASED

(Type or print)

First

Middle

Last

4. DATE OF DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

7. Married ☒ Never Married ☐Widowed ☐ Divorced ☐

8. DATE OF BIRTH

9. AGE (last birthday)

IF UNDER 1 YEAR

IF UNDER 24 HR

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)

12. CITIZEN OF WHAT COUNTRY

13a. FATHER'S NAME

13b. MOTHER'S MAIDEN NAME

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

Sub phrenic abscess

E. coli

DUE TO (c)

arteriosclerotic heart disease

INTERVAL BETWEEN ONSET AND DEATH

4 days

4 weeks

21

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED?

YES ☒ NO ☐

20a. ACCIDENT SUICIDE HOMICIDE

☐ ☐ ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY

Hour a.m. p.m.

Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from

Jan. 6th 1953 to 4-30-63

and last saw him alive on 4-30-63

Death occurred at

5:30 p.m.

on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

(State)

24. FUNERAL DIRECTOR

ADDRESS

25. DATE RECD. BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

WILL MARTINEZ 6409 Gravois Ave.

MAY 1 1963

Rosal Smith, M.D.

USE BLACK INK

OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DATE AMENDED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300
Rev. 4/59

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DR. D. J. Veredg
Lister Bldg.
Alton 3 p.m.
4500 Ohio

FD-7-7420

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Sam M. Szymon
Licensed Embalmer No. 4343

P. O. Address St Louis Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.